VALEO
HEALTH AND WELLNESS CENTER

Office Use Only
Practitioner: AM DB JT MM RL
Appt Type: CHIRO FUNC MASS
Appt Date _____ ☐ CT ☐ C ☐ Thank You

PERSONAL INFORMATION

Name:	**Guardian's Name (if minor):**		
Today's Date:	**Date of Birth:**		**Age:**
Address:	**Height:**	**Weight:**	**Gender:**
City:	**Email Address:**		
State: **Zip:**	**Ph: H/C**		
Preferred Contact: ◯ Phone ◯ Email	**Do you have MEDICARE?** ◯ Yes ◯ No		
Marital Status (Dropdown):	**Would you like to receive our newsletter?** ◯ Yes ◯ No		

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact	Relationship to Patient	Phone Number

REFERRAL INFORMATION

How were you referred to our office? (Dropdown)

Name of referrer or event (so that we can thank them):

GOALS FOR MY CARE

People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes.

◯ Relief Care: Symptomatic relief of pain or discomfort

◯ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

◯ Comprehensive Care: Address the entire system and bring your body to the highest state of health possible.

Any other goals you'd like to share?

THE BEGINNING YEARS

Birth to 17 years of age	NO	YES	EXPLAIN
Did you have any serious childhood illness?			
Did you have any serious falls as a child?			
Was there prolonged use of medicine such as antibiotics or an inhaler?			
Were you vaccinated?			
Adult: 18 YO to Present			
Are you pregnant? If yes, when are you due?			
Do you have a pacemaker?			
Do you have any metal in your body?			
Do you exercise regularly?			
Do you have any scars?			

HEALTH CONCERNS - List according to severity. Rate from 1 (mild) to 10 (unbearable)

Health Concern	Severity	Episode Start Date?	Had this before? When?	Constant or Intermittent?

Since the problem started, is it (Please Check):

◯ Same ◯ Improving ◯ Worse

Does it travel/radiate?

◯ No ◯ Yes, where?

What makes it better?

What makes it worse?

Do you have a family history of this or similar symptoms?

◯ No ◯ Yes/explain:

Have you seen other doctors for this condition? ◯ No ◯ Yes

☐ Medical ☐ Chiropractor ☐ Other:

If yes, what Yes, diagnosis:

What was done?

Do you have allergies/sensitivities to fragrances or oils?

◯ No ◯ Yes, explain:

Do you have any known allergies?

◯ No ◯ Yes, explain:

How have you taken care of your health in the past?

☐ Medications ☐ Emergency Room ☐ Routine Medical
☐ Exercise ☐ Nutrition/Diet ☐ Holistic Care
☐ Vitamins ☐ Chiropractic ☐ Other:

How have the previous method(s) work out for you?

☐ Bad results ☐ Some results ☐ Great Results
☐ No change ☐ Still trying ☐ Other:

Are you concerned that this condition is or will negatively affect any of the following?

☐ Job ☐ Marriage ☐ Kids ☐ Future Ability
☐ Sleep ☐ Self-esteem ☐ Freedom ☐ Finances
☐ Time ☐ Other

Are you concerned that your helath conditions(s) might turn into any of the following?

☐ Family health problems ☐ Heart Disease ☐ Cancer
☐ Fibromyalgia ☐ Depression ☐ Chronic Fatigue
☐ Diabetes ☐ Arthritis ☐ Other

Have your health condition(s) affected your job, finances, relationships, family or other activities?

☐ No
☐ Yes, explain:

If you have health issues, what have they cost you?

☐ Time ☐ Money ☐ Hope ☐ Happiness
☐ Sleep ☐ Freedom ☐ Please explain:

PAST ACCIDENTS/SURGERIES/INJURIES/PROCEDURES: List all (auto/work), x-rays, trauma (physical/emotional)

Type	Date	Doctor/Hospitalization/x-rays/Procedure

List all prescription drugs, over-the-counter drugs, and all supplements you are currently taking

Name of drug or supplement	Taken for how long?	For what purpose?	How much?

HIPAA ACKNOWLEGEMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Valeo Health & Wellness Center's Notice of Privacy Practices. Valeo is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at any time.

Client Name: _____

Signature of patient (or parent, if minor): _____ Date _____

VALEO PAYMENT POLICY

RETURNED CHECK POLICY - If you pay with a check that is returend due to insufficient funds, we will require immediate payment in another form plus a $35.00 returned check fee and any bank charges. If there is no response from you, we must send this to collections.

SERVICE AGREEMENT - I clearly understand and agree that all services and products rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. Valeo will work with you regarding payment plans if necessary. There will be an 18% APR charged on balances over 30 days past due. Anything older than 120 days will be sent to collections. Please contact us if you have any questions regarding this policy.

Signature: _____ Date: _____

INSURANCE PAYMENT AGREEMENT - *FOR PERSONAL INJURY, WORK COMP OR MEDICARE ONLY:*
I understand that insurance will be billed for Valeo services and I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Signature: _____ Date: _____

POLICIES AND PROCEDURES

1. The practitioners design specific health plans in order for you to get better in the shortest amount of time. It is to your benefit to maintain your visit schedule and care plan as explained to you in the Report of Findings. The practitioners take your health very seriously and we ask that you do the same.

2. If you need to cancel or reschedule an appointment, please provide the office with at least a 24-hour notice. Our goal is to stay on time; however, occasionally emergencies or unforseen circumstances arise where the practitioner will spend more time with a patient. We will do our best to inform you if the practitioner is running behind schedule.

Daily Record of Food Intake | *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Name:

Day 1 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 2 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 3 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Notes:

Day 4 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 5 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 6 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Day 7 - Date:

BREAKFAST *Time:*	***LUNCH*** *Time:*	***DINNER*** *Time:*
Meat & Dairy:		
Vegetables & Fruits:		
Breads, Cereals, & Grains:		
Fats (butter, margarine, oils, etc.):		
Candy, Sweets, & Junk Food:		
Water Intake (fl. oz.):		
Other Drinks:		
MID-MORNING SNACK *Time:*	***MID-DAY SNACK*** *Time:*	***NIGHTTIME SNACK*** *Time:*
Snack:		
Bowel Movements*(# and consistency):*	***Hours of Sleep:***	***Quality of Sleep:*** (good) 1 2 3 4 5 (poor)

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3

Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? **Yes** **No**

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3

Have you had your gallbladder removed? **Yes** **No**

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes			No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

NAME: DATE:

Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal (Areas 9, 10, 11, and 12)		Level
1.	Difficulty with restraint and controlling impulses or desires	⓪①②③④
2.	Emotional instability (lability)	⓪①②③④
3.	Difficulty planning and organizing	⓪①②③④
4.	Difficulty making decisions	⓪①②③④
5.	Lack of motivation, enthusiasm, interest and drive (apathetic)	⓪①②③④
6.	Difficulty getting a sound or melody out of your thoughts (Perseveration)	⓪①②③④
7.	Constantly repeat events or thoughts with difficulty letting go	⓪①②③④
8.	Difficulty initiating and finishing tasks	⓪①②③④
9.	Episodes of depression	⓪①②③④
10.	Mental fatigue	⓪①②③④
11.	Decrease in attention span	⓪①②③④
12.	Difficulty staying focused and concentrating for extended periods of time	⓪①②③④
13.	Difficulty with creativity, imagination, and intuition [R]	⓪①②③④
14.	Difficulty in appreciating art and music [R]	⓪①②③④
15.	Difficulty with analytical thought [L]	⓪①②③④
16.	Difficulty with math, number skills and time consciousness [L]	⓪①②③④
17.	Difficulty taking ideas, actions, and words and putting them in a linear sequence [L]	⓪①②③④

Frontal Lobe Precentral and Supplementary Motor Areas (Area 4 and 6)		Level
18.	Initiating movements with your arm or leg has become more difficult	⓪①②③④
19.	Feeling of arm or leg heaviness, especially when tired	⓪①②③④
20.	Increased muscle tightness in your arm or leg	⓪①②③④
21.	Reduced muscle endurance in your arm or leg	⓪①②③④
22.	Noticeable difference in your muscle function or strength from one side to the other	⓪①②③④
23.	Noticeable difference in your muscle tightness from one side to the other	⓪①②③④
Frontal Lobe Broca's Motor Speech Area (Area 44 and 45)		**Level**
24.	Difficulty producing words verbally, especially when fatigued	⓪①②③④
25.	Find the actual act of speaking difficult at times	⓪①②③④
26.	Notice word pronunciation and speaking fluency change at times	⓪①②③④
Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3,1,2 and 7)		**Level**
27.	Difficulty in perception of position of limbs	⓪①②③④
28.	Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall	⓪①②③④
29.	Frequently bumping body or limbs into the wall or objects accidently	⓪①②③④
30.	Reoccurring injury in the same body part or side of the body	⓪①②③④
31.	Hypersensitivities to touch or pain perception	⓪①②③④

Brain Region Localization Form

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KEY:

0 = I never have symptoms (0% of the time)
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2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

Parietal Inferior Lobule (Area 39 and 40)		Level
32.	Right/left confusion [L]	0 1 2 3 4
33.	Difficulty with math calculations [L]	0 1 2 3 4
34.	Difficulty finding words [L]	0 1 2 3 4
35.	Difficulty with writing [L]	0 1 2 3 4
36.	Difficulty recognizing symbols or shapes [R]	0 1 2 3 4
37.	Difficulty with simple drawings [R]	0 1 2 3 4
38.	Difficulty interpreting maps [R]	0 1 2 3 4
Temporal Lobe Auditory Cortex (Areas 41, 42)		**Level**
39.	Reduced function in overall hearing	0 1 2 3 4
40.	Difficulty interpreting speech with background or scatter noise	0 1 2 3 4
41.	Difficulty comprehending language without perfect pronunciation	0 1 2 3 4
42.	Need to look at someone's mouth when they are speaking to understand what they are saying	0 1 2 3 4
43.	Difficulty in localizing sound	0 1 2 3 4
44.	Dislike of left predictable rhythmic, repeated tempo and beat music [L]	0 1 2 3 4
45.	Dislike of non-predictable rhythmic with multiple instruments [R]	0 1 2 3 4
46.	Noticeable ear preference when using your phone	○ right, ○ left, ○ no preference
Temporal Lobe Auditory Association Cortex (Area 22)		**Level**
47.	Difficulty comprehending meaning of spoken words [L]	0 1 2 3 4
48.	Tend toward monotone speech without fluctuations or emotions [R]	0 1 2 3 4

Medial Temporal lobe and Hippocampus		Level
49.	Memory less efficient	0 1 2 3 4
50.	Memory loss that impacts daily activities	0 1 2 3 4
51.	Confusion about dates, the passage of time, or place	0 1 2 3 4
52.	Difficulty remembering events	0 1 2 3 4
53.	Misplacement of things and difficulty retracing steps	0 1 2 3 4
54.	Difficulty with memory of locations (addresses) [R]	0 1 2 3 4
55.	Difficulty with visual memory [R]	0 1 2 3 4
56.	Always forgetting where you put items such as keys, wallet, phone, etc. [R]	0 1 2 3 4
57.	Difficulty remembering faces [R]	0 1 2 3 4
58.	Difficulty remembering names with faces [L]	0 1 2 3 4
59.	Difficulty with remembering words [L]	0 1 2 3 4
60.	Difficulty remembering numbers [L]	0 1 2 3 4
61.	Difficulty remembering to stay or be on time (reduced left) [L]	0 1 2 3 4
Occipital Lobe (Area, 17, 18, and 19)		**Level**
62.	Difficulty in discriminating similar shades of color	0 1 2 3 4
63.	Dullness of colors in visual field	0 1 2 3 4
64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects	0 1 2 3 4
66.	Floater or halos in visual field	0 1 2 3 4

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

Cerebellum - Spinocerebellum		Level
67.	Difficulty with balance, or balance that is worse on one side	0 1 2 3 4
68.	A need to hold the handrail or watch each step carefully when going down stairs	0 1 2 3 4
69.	Feeling unsteady and prone to falling in the dark	0 1 2 3 4
70.	Proness to sway to one side when walking or standing	0 1 2 3 4
Cerebellum - Cerebrocerebellum		**Level**
71.	Recent clumsiness in hands	0 1 2 3 4
72.	Recent clumsiness in feet or frequent tripping	0 1 2 3 4
73.	A slight hand shake when reaching for something at the end of movement	0 1 2 3 4
Cerebellum - Vestibulocerebellum		**Level**
74.	Episodes of dizziness or disorientation	0 1 2 3 4
75.	Back muscles that tire quickly when standing or walking	0 1 2 3 4
76.	Chronic neck or back muscle tightness	0 1 2 3 4
77.	Nausea, car sickness, or sea sickness	0 1 2 3 4
78.	Feeling of disorientation or shifting of the environment	0 1 2 3 4
79.	Crowded places cause anxiety	0 1 2 3 4
Basal Ganglia Direct Pathway		**Level**
80.	Slowness in movements	0 1 2 3 4
81.	Stiffness in your muscles (not joints) that goes away when you move	0 1 2 3 4
82.	Cramping of hands when writing	0 1 2 3 4
83.	A stooped posture when walking	0 1 2 3 4
84.	Voice has become softer	0 1 2 3 4
85.	Facial expression changed leading people to frequently ask if you are upset or angry	0 1 2 3 4
Basal Ganglia Indirect Pathway		**Level**
86.	Uncontrollable muscle movements	0 1 2 3 4
87.	Intense need to clear your throat regularly or contract a group of muscles	0 1 2 3 4
88.	Obsessive compulsive tendencies	0 1 2 3 4
89.	Constant nervousness and restless mind	0 1 2 3 4
Autonomic Reduced Parasympathetic Activity		**Level**
90.	Dry mouth or eyes	0 1 2 3 4
91.	Difficulty swallowing supplements or large bites of food	0 1 2 3 4
92.	Slow bowel movements and tendency for constipation	0 1 2 3 4
93.	Chronic digestive complaints	0 1 2 3 4
94.	Bowel or bladder incontinence resulting in staining your underwear	0 1 2 3 4
Autonomic Increased Sympathetic Activity		**Level**
95.	Tendency for anxiety	0 1 2 3 4
96.	Easily startled	0 1 2 3 4
97.	Difficulty relaxing	0 1 2 3 4
98.	Sensitive to bright or flashing lights	0 1 2 3 4
99.	Episodes of racing heart	0 1 2 3 4
100.	Difficulty sleeping	0 1 2 3 4

VALEO
HEALTH AND WELLNESS CENTER

Is Your Life Out Of Balance?

DIRECTIONS: On a scale from 1-10, where (10) is the highest and (1) is the lowest, please rate your current "health level" in each significant area of your life.

Relationship / Family Life

Are you in a loving relationship? Do you feel like you spend enough quality time with your family? Do you have a close connection with your children, parents, and relatives? Do you have poor family relationships from the past or present that negatively impact your health?

Leisure

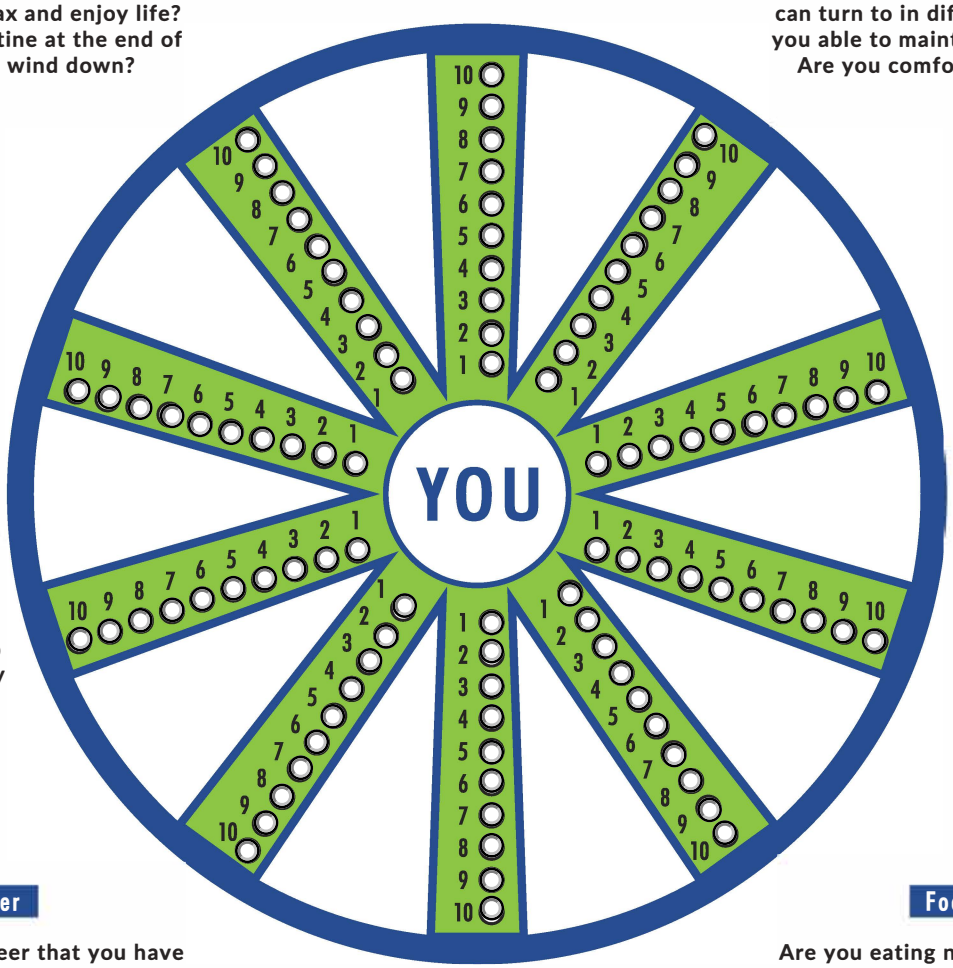
Are you taking regular vacations without bringing work with you? Do you have time set aside each week to relax and enjoy life? Do you have a healthy routine at the end of the day that helps you wind down?

Social Health

Do you have a connection with at least one other person, outside your family, who you can turn to in difficult and good times? Are you able to maintain long-term friendships? Are you comfortable in social settings?

Environmental

Do you regularly enjoy time out in nature? Do you spend time doing outdoor activities such as sports, camping, fishing, hiking, etc.? Are you aware of toxins in your environment? If you are aware of certain environmental toxins, do you limit your exposure to them?



Intellectual

Are you open to new ideas? What is the quality of the information and entertainment that you allow into your mind? Do you challenge yourself to learn new things and hobbies?

Spiritual

Do you feel that you have a close/strong relationship with God? Do you regularly study, meditate, pray or worship? Do you regularly attend fellowship with others whom share the same beliefs as yourself?

Physical

Do you have plenty of energy? Do you exercise, eat healthy and drink plenty of water on a regular basis? Are you limited in what you can do because of physical ailments?

Job / Career

Are you working in the career that you have always wanted to be working in? Does your job stimulate you, give you energy or drain your energy? Does your career allow you to live the lifestyle you desire? Are you working in a position or towards a career that you feel God has planned for you?

Food / Nutrition

Are you eating natural/organic foods? Are you skipping meals? Do you plan out your meals ahead of time? Do you take whole-food supplements?

Psychological / Emotional / Stress

Do you have a positive attitude even during stressful times? Does your stress level overwhelm you? Do you have peace in your life?

Name:

Date:

SCORE:

Your Well Score

1. Copy your score from the front and write it here _____ / 100.

2. Knowing the score you wrote down, what would you like your total score to be?_____

3. What do you think the time frame will be to achieve that number? _____

4. Of the ten categories on the front, what area of your life would you like to change the most?

_____

5. What changes in your life do you think will need to be made in order for you to achieve your goal(s)? Please check all that apply below.

☐ Exercise ☐ Diet Changes ☐ Supplements ☐ Body Cleanse ☐ Chiropractic Care

☐ Massage Therapy ☐ Medical Treatment ☐ Counseling ☐ Spiritual Healing

☐ Other _____

6. How will your life improve as a result of making these changes?

_____

_____

_____

_____

11800 Singletree Lane / Suite #205 / Eden Prairie / MN 55344
Phone: (952) 949-0676 / Fax: (952) 949-0868 / Web: www.valeowc.com